Review of CSB Child & Adolescent Services

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Three Phases

- Survey of all 40 CSBs - Nov 2007
  - Services provided, structure staffing & budget
- Site visits to 34 CSBs - March/April 2008
  - Interviewed 175 family, 1,000 staff/supervisors
  - Reviewed 469 case records
- On line survey of 1,500 agency stakeholders
  - DSS, Schools, Juv. Justice, Health, family members
  - Views of CSB as provider/CSA partner
  - Community service needs & gaps
  - Priority services to reduce residential placements

2007 Snapshot of System

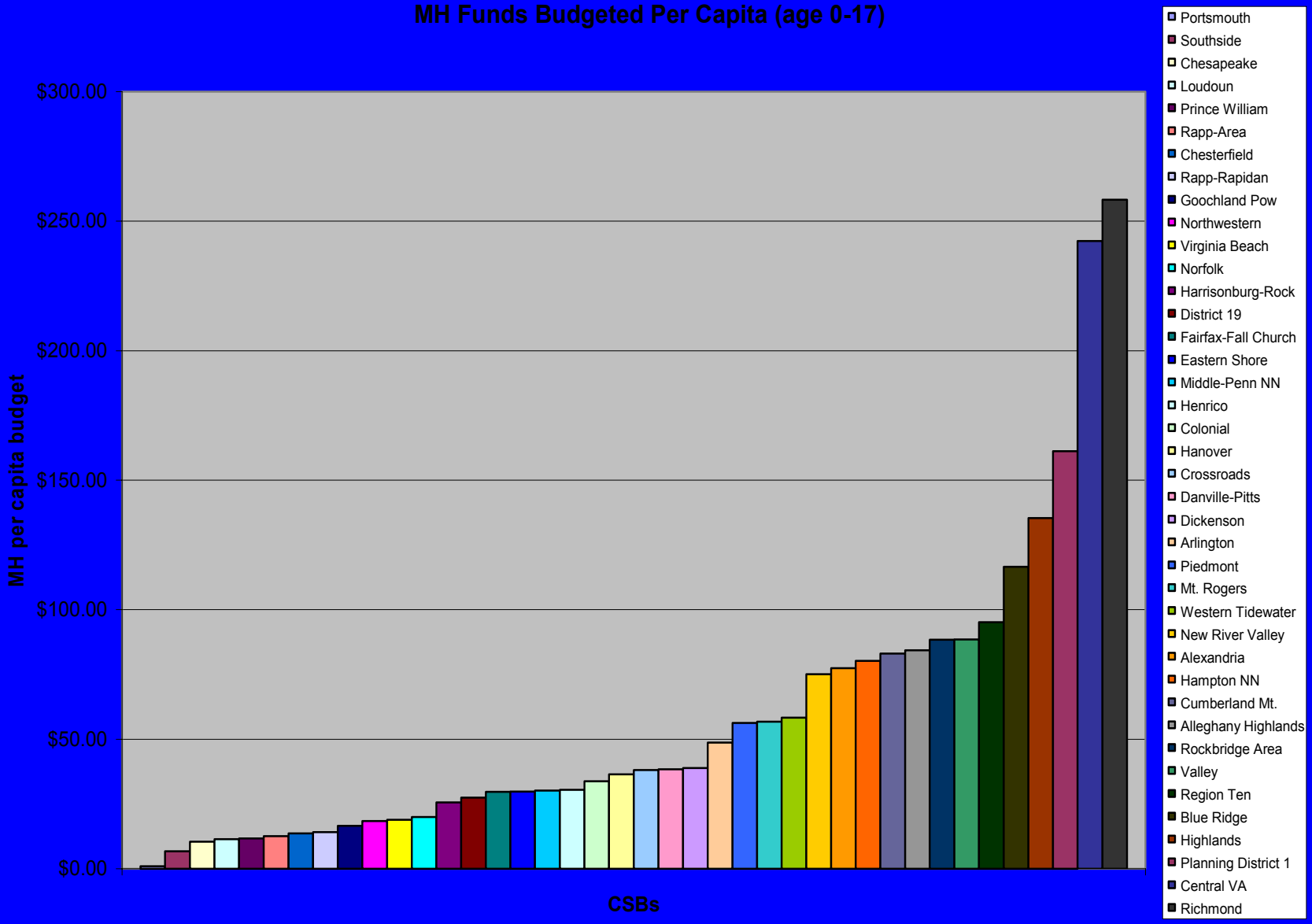
- CSBs served 42,089 children & adolescents
  - 29,357 in mental health programs
- CSBs budgets for MH/ID/SA $119.02 million
  - Mental Health - $91.07 million
  - Substance Abuse - $14.99 million
  - Intellectual Disability – 12.96 million

Finding – Wide Variation in Service Availability

Families seeking services for children and adolescents with MH, SA or ID service needs face enormous differences in service availability depending on where they live. Whether measured by expenditures, staffing, or percentage of child population served, the availability of services for children and adolescents offered by CSBs varies widely among communities.

Wide Variability in MH Access

- Per capita MH funding based on child population in service area:
  - Highest $258.36 per child
  - Lowest $0.96 per child
- Staffing:
  - Highest 1 staff to 237 children
  - Lowest 1 staff to 15,380 children
- Service penetration:
  - Highest 10.21% of population
  - Lowest .38% of population


MH Funds Budgeted Per Capita (age 0-17)
$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$0.00
MH per capita budget
CSBs
Portsmouth
Southside
Chesapeake
Loudoun
Prince William
Rapp-Area
Chesterfield
Rapp-Rapidan
Goochland Pow
Northwestern
Virginia Beach
Norfolk
Harrisonburg-Rock
District 19
Fairfax-Fall Church
Eastern Shore
Middle-Penn NN
Henrico
Colonial
Hanover
Crossroads
Danville-Pitts
Dickenson
Arlington
Piedmont
Mt. Rogers
Western Tidewater
New River Valley
Alexandria
Hampton NN
Cumberland Mt.
Alleghany Highlands
Rockbridge Area
Valley
Region Ten
Blue Ridge
Highlands
Planning District 1
Central VA
Richmond

Findings – Sources of Funding

- State general funds and local funding make up a comparatively small portion of total funds for child & adolescent MH services statewide.
  - 10.7% state
  - 12% local
- CSA funds paid to CSBs for purchase of services is only 8.6% of MH budgets.
- 72% of CSBs have less than 10% of funding from CSA.

Findings – Sources of Funding

- Medicaid is the largest source of funding for CSB child & adolescent MH services statewide – 54.1% of total funds.
- CSBs that have developed the most extensive systems of services for children and adolescents have done so primarily through the use of Medicaid .

Findings – Service Availability

- Few CSBs offer a large array of child & adolescent services with sufficient capacity to meet the needs of their community. Many CSBs have very limited services available. A few have virtually no services system designed especially for children.
- C/A services at CSBs are full to capacity, resulting on long waiting periods.
- Access to services for uninsured families is extremely limited.

Findings – Service Availability

- Stakeholder agency representatives express dissatisfaction with the levels of CSB service availability in their communities
  - Wait time for access to services is too long
  - Wide array of services needed to serve children is not available
  - Services to children with substance abuse needs & autism spectrum disorders are inadequate

CSB Average Wait Time for MH Outpatient Services

Professional	Wait Time (Days)
Clinician	37.42
Clinician Post emergency	16.50
Psychiatrist	30.36
Psychiatrist Post emergency	15.46

CSB Outpatient Staff FTEs Per 50,000 Population

Staff FTEs per 50,000 pop	Number of CSBs
0 FTEs No Service	1 (2.5%)
.01 to 1 FTEs	11 (27.5%)
1.01 to 2 FTEs	22 (55%)
2.01 to 3 FTEs	4 (10%)
3.01 to 4.00	2 (5%)
4.01+	0

Change in CSB OP Capacity Over Past 10 Years

	Number of CSBs
Increased capacity	15 (37.5%)
Decreased Capacity	22 (55%)
No Change	3 (7.5%)

Impact of Limited OP Capacity

- Often not possible to prevent crises
- Individuals seeking service lose interest and fail to follow through
- Staff have limited time to follow up on those who drop out
- Not possible to meet the needs of the court for outpatient commitment
- Court ordered treatment will cause delays for those who seek treatment voluntarily

Findings – Service Quality

- Parents/caregivers of children receiving services at CSBs report very high levels of satisfaction.
- Family level of involvement with CSB staff in planning & provision of services is quite high.
- Progress toward treatment goals is generally good.

Findings – Service Quality

- CSB assessments for co-occurring SA needs in children receiving MH services were not comprehensive. When SA was identified, SA treatment goals present only half the time.
- Few CSBs offer nationally recognized “evidence-based practices”.
- Access to services for parents/caregivers & coordination with children’s services not adequate.

Family Interviews

	Agree	Disagree
Involved in treatment planning	88.6%	8.6%
Satisfied with amount of time	91.4%	7.4%
Getting as much help as need	85.2%	14.8%
Child/family benefits fm services	93.2%	6.8%
Noticed improvement	85.2%	14.2%
Satisfied with services	96%	3.4%

Findings – CSA/Interagency Coordination

- CSBs are not the provider of choice for community-based CSA-funded MH services in many communities. Just over half of stakeholders say CSB fills this role.
- Many agency stakeholders say their CSBs do not make clear what services they offer or who is eligible.

Findings – CSA/Interagency Coordination

- While majority of community stakeholders rate CSB cooperativeness and communication favorably, a large minority provide negative ratings.
- Over half the CSBs have developed one or more specific services to help improve the provision of services offered to children in the CSA system. (intensive care coordination & utilization management)

Findings – CSB Workforce

- CSBs have great difficulty recruiting and retaining qualified staff to provide children's services.
- CSBs have inadequate psychiatric time to meet the needs of the children in their communities. Only 12.5% of CSBs report adequate psychiatric resources. There are long wait times to see a psychiatrist. CSBs estimate that 25 FTE psychiatrists are needed statewide.
- CSB staff describes morale as very high.

Stakeholder Interviews - 520

Social Services	145
Public Schools	77
Juvenile/Domestic Relations Court	58
Heath Department	34
Private Provider	47
Family Member	12
Other	147

Stakeholder Survey

	Agree	Disagree
I am usually satisfied with results of CSB services	60.7%	37.4%
CSB is usually provider of choice for FAPT/CPMT	62.9%	34.9%
CSB collaborates with my agency in planning for child	64.8%	31.1%
CSB is vigorous & effective partner in our local CSA	62.6%	35%

Stakeholder Survey

	Agree	Disagree
CSB keeps me informed about progress of treatment	48%	37%
CSB involves families in assessment & planning	78.3%	10.9%
CSB MH services have good treatment outcomes	57.3%	35.3%
CSB emergency program is responsive, effective means to keep child in community	52.2%	43%

Stakeholder Survey

	Agree	Disagree
I find that most of children I see with MH needs can be served by the CSB	44%	51%
CSB does good job of meeting needs of children with mental retardation	54.9%	27.9%
CSB does good job of meeting needs of children with substance abuse probs.	39%	42%

What does your CSB do well?

Cooperate, collaborate w/ agencies, improves system
Provides effective/excellent services
Leader/expert on MH issues in community
Provides specialized services to children w/ DD/ID
Targeting services to indigent children/families
Active partner in CSA processes
Substance abuse evaluations & treatment/prevention

What is your biggest criticism of the CSB?

Waiting list. Takes too long to start services.
Do not offer comprehensive range of needed services.
CSB is not collaborative with other agencies
CSB does not provide adequate SA services
Eligibility for services for those without Medicaid, insurance or CSA is very limited.

What service would help prevent residential placement out of community?

Home-based intensive services – wrap around srvs
Substance abuse outpatient services
Residential options in community
Mental health outpatient services
Broader range of assessment and evaluation services
Educational support and treatment for families/parents
Comm-based srvs for sexually acting-out children

Factors Most Help Development of CSB Child/Adol MH Services

- Community requests, needs, support for development of services
- Creation of CSA, support of partner agencies
- Creation & growth of Medicaid funding
- Leadership of our executive director & Child/Adolescent services director

Factors Most Hindering Development of CSB Child/Adol MH Services

- Lack of funding flexibility
- Difficulty recruiting and retaining qualified child staff
- Transportation for families and staff
- Agency structure limits priority for children
- Difficulty finding and attracting psychiatrists

What CSBs Indicate State Should do to Develop Child MH Services

- DBHDS provide training
- Expand types of services eligible for reimbursement (Medicaid) – non-SED, at risk, prevention, non-mandated
- DBHDS reflect priority in all areas/activities/policies
- Create mandate for local child MH services, school-based, etc.
- Assist communities with providing psychiatric services, work with communities

Leading Determinants of CSB C/A Serv's Development – Per OIG

- Extent to which leadership is exercised to place priority on development of services, to establish community & interagency relationships, to use creativity in making use of funding from Medicaid, grants & CSA
- Limited availability of funding to serve uninsured families.
- Relatively limited use of CSBs by local communities to provide CSA Services.

OIG Recommendations

1. DBHDS lead interagency process to develop a plan for the provision of publicly supported , community based MH/ID/SA services for children, adolescents and their families no later than July 2009. Present plan to General Assembly and then present progress reports in subsequent years.

OIG Recommendations

2. Every CSB appoint a single person to lead services for children & adolescents.
3. DBHDS provide leadership in determining areas of training needed to increase consistency in service quality and develop plan for assuring availability of needed training

OIG Recommendations

4. CSBs that have developed more comprehensive systems of services share information with other CSBs regarding organizational, interagency collaboration, staffing and funding factors that have enabled success.
5. CSBs evaluate methods for assessing SA to assure comprehensive evaluation of need for SA treatment.

Office of the Inspector General

Behavioral Health and Developmental Services

OIG Reports #148-07 & #149-08

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